



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part A: Ambulance Service
License Application



1) Service Number 	2) Service Expiration Date	3) Is this application ____ Initial ____ Renewal ____ Modification Modification of License to: ____ Advanced ____ Paramedic ____ Critical Care Transport
4) SERVICE INFORMATION		
Name		
Address		P.O. Box
City	State	Zip
Business Phone Number ()	Fax Number ()	
Manager Name	Contact Person	E-mail address
7) LICENSEE INFORMATION		
Name		
Address		
City	State	Zip
Business Phone Number ()	24 Hour Access Number, Non 911 ()	
E-mail address	24 Hour Access Fax Number ()	
8) PARENT or ASSOCIATED COMPANIES OF OWNER		
Name		
Address		
City	State	Zip
9) Service Ownership Type?	Sole Proprietor Government	Partnership Corporation LLC Limited Partnership Other:
10) Is this service hold other valid licenses in the Commonwealth of Massachusetts? <input type="checkbox"/> YES <input type="checkbox"/> NO		
11) Level of License applying <input type="checkbox"/> BLS <input type="checkbox"/> Advanced <input type="checkbox"/> Paramedic <input type="checkbox"/> Critical Care		
12) With which hospital(s) do you have an affiliation agreement or memorandum of understanding or medication exchange?		
Hospital Name	ALS	Glucose Monitoring Alb/Narcan EPI/Aspirin
13) Total number of vehicles		
Class I	Class II	Class IV Class V EFR
14) Total number of EMS personnel EMTs: Basic: Intermediate: Advanced: Paramedic:		Services uses Paramedic/ Basic Minimum Staffing YES NO
15) Does the ambulance service respond ONLY to calls from a unique population? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, identify population(s): _____		
16) Indicate the number of runs performed by this service in the last calendar/fiscal year		____/____/____ Date From
____/____/____ Date To		Yes / No Are numbers estimated?
Total Number of Responses (incl cxl, refusal):		
Emergency Transports BLS:	Emergency Transports ALS:	Routine Transports BLS:
Routine Transports ALS:		Total Transports:
17) Do you currently have any Waivers?		
Check	Waiver Type	Extension Requested
	Vehicle Waivers	YES NO
	Service Operation Waivers	YES NO
	Special Project Waiver	YES NO
	Other	YES NO
OEMS use only	Fee Received	Amount

Part A: Ambulance Service License Application

STATEMENT OF NON-DISCRIMINATION

Pursuant to 105 CMR 170.335 of the Emergency Medical Services System Regulations, Regulating Ambulances and Ambulance Services, "no person shall discriminate on the grounds of race, color, religion, national origin, sex, sexual orientation, age, ancestry or disability in any aspect of its provision of ambulance or EMS first response service or in employment practices. This section requires compliance with M.G.L. c. 151B, as amended, which is a statute prohibiting unlawful discrimination."

This ambulance service is and will continue to be in conformance with these requirements.

TAX CERTIFICATION STATEMENT

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

This license will not be issued unless this certification clause is signed by the applicant.

Your tax identification number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or are delinquent **WILL BE SUBJECT TO LICENSE SUSPENSION OR REVOCATION**. This request is made under the authority of M.G.L. c. 62C s. 49A.

18) License social security or federal identification number:

19) Does this service have any outstanding assessments levied by the Commonwealth of Massachusetts?

☐ YES

☐ NO

I understand that additional information may be required by the Massachusetts Department of Public Health to complete the application process, and agree to provide such information as requested. I, the undersigned, attest that I am duly authorized to complete and sign this application, that I have read this application in its entirety and that the information contained herein is complete, accurate and true. Signed under the pains and penalties of perjury.

Authorized Signature _____ Date _____

Print Name _____ Date _____

FEE INFORMATION

Fee must accompany application or a letter of explanation must be submitted.
Applications will not be submitted to Public Health Council until fee has been received.

FEES ARE AS FOLLOWS:

BLS only: \$400 ambulance service license, plus \$200 per vehicle for Certificates of Inspection, OR

ALS (and BLS): \$600 ambulance service license, plus \$200 per vehicle for Certificates of Inspection.

ALS Upgrade: \$600 ambulance service license upgrade (no Certificate of Inspection fee required if the upgrade is not at time of relicensure)

Make check(s) payable to Commonwealth of Massachusetts.

Return completed application packet, fee and proof of insurance to:

**Office of Emergency Medical Services
99 Chauncy Street, 11th Floor
Boston, MA 02111**



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part B-1: Service Area



1) Service Number

2) Ambulance Service Name

In Column #3 list the communities in which you regularly respond to emergency calls. Circle "full" if you are the primary emergency provider for the entire community (attach written explanation). Indicate whether or not your service is the municipality designated emergency service. Indicate whether or not you respond only to a unique population (state institution, industrial plant, university, etc.)

In Column #4 list those ambulance services to which your service provides back up.

Please list those communities or portions of communities in which you routinely respond to emergencies.				
OEMS use only	3) Primary Emergency Coverage City / Town Name	Cover Full/Part Town	Municipal Designate	Unique Pop.
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO
		FULL PART	YES NO	YES NO

Please list those Ambulance Services your service backs up	
OEMS use only	4) Back-up Ambulance Services Service Name



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part C: EMS Personnel List



1) Service Number

2) Ambulance Service Name

DIRECTIONS: You may use this form (make as many copies as you need) or you may submit a computer-generated list provided that it includes the same information about each ambulance attendant the service employs (name, EMT certification number, level, and employment status). Please print or type names in alphabetical order. Be sure that the six digit EMT certification number is accurate. Circle the appropriate level. B=Basic, I=Intermediate, and P=Paramedic. Check the appropriate space for the employment status of each EMT.

REMINDER: 105 CMR 170.345 requires services to maintain records that document each attendant's current CPR certification, EMT certification, and valid motor vehicle operator's license including when and by whom verification of original certification was completed.

3) Attendant's Name	4) EMT Number	Circle 1	Check 1		
		5) Level	6) Full/Part Time Paid	6) Paid Per Diem	6) On Call or Volunteer
		B I P			
		B I P			
		B I P			
		B I P			
		B I P			
		B I P			
		B I P			
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		B I P			
		B I P			
		B I P			



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part D: Place of Business



Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances (Make as many copies of this form as needed). This form is also used when adding new or changing addresses.

170.240: Modification of a Service License

(A) Pursuant M.G.L. c. 111C, §8(a), any service seeking to modify any term of its license shall obtain the approval of the Department prior to making any modification. A service shall request approval to modify on forms provided by the Department. (B) Approval for a license modification shall be required for, but not limited to, the following: (1) When a new certificate of inspection for an EMS vehicle is issued or when a certificate of inspection is revoked by the Department or deleted by the service; (2) When a change is made in the level of service; or (3) When a service adds or deletes a place of business from which services are provided. (C) The Department shall not grant approval for a license modification unless it finds that the modification requested is in the public interest. If the modification requested involves a substantial change in the nature and scope of services, the Department shall also find that such change serves a need for emergency medical care before approving the modification.

1) Service Number 		2) Ambulance Service Name	
3) PLACE OF BUSINESS			
Address			
City		State	Zip
Business Phone Number [For this location] ()		New Location	Yes No
		Address Change	Yes No
		Delete Location	Yes No

4) Is this location your headquarters? ☐ YES ☐ NO Fax Phone Number () _____

5) Number of vehicles normally operated at this location				
Class I	Class II	Class IV	Class V	

6) Is service from this place of business provided 24 hours a day, 7 days a week? ☐ YES ☐ NO

If no, please explain:

7) What type of service(s) is being provided from this location? (Check all that apply)		<input type="checkbox"/> Basic <input type="checkbox"/> ALS-Intermediate <input type="checkbox"/> ALS-Advanced <input type="checkbox"/> ALS-Paramedic				
8) How many hours per day is ALS-Intermediate service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
9) How many hours per day is ALS-Paramedic service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
10) ALS Information: Have you applied to the Departments Drug Control Program <input type="checkbox"/> Yes <input type="checkbox"/> No						
Mass Controlled Substance Registration # _____ Expiration _____ Schedule _____						
Hospital with which you have an Affiliation Agreement _____						
11) Back Up Agreement Information: Please attach backup agreements as required under 105 CMR 170.385 Have you attached backup agreements? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the primary service zone provider been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No						

You must submit this form with proper attached documentation and with Department approval prior to base operation



Massachusetts Department of Public Health

Office of Emergency Medical Services Part E: Vehicle Certification



Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances. (Make as many copies of this form as needed).

Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances. (Make as many copies of this form as needed).

1) Service Number ____	2) Service Expiration Date ____	3) Is this vehicle a(n) ____ Addition ____ Replacement ____ Renewal
4) SERVICE INFORMATION		
Service Name ____		
Service Address ____		
Service City ____	Service State ____	Service Zip ____
Business Phone Number (____) ____	Business Fax Number (____) ____	
Vehicle Location Address (if not Garaged at Service Address) ____		
Vehicle Location City ____	Vehicle Location State ____	Vehicle Location Zip ____

4) Has this vehicle been previously certified to another service in Massachusetts? ☐ YES ☐ NO

6) Vehicle Identification Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

7) License Plate Number _____ Vehicle Garaged at _____

8) Vehicle Unit ID unique to your serviced _____ Replacement for Vehicle # _____

9) Chassis Make (Manufacturer) ____	Model ____	Year ____
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10) Has this chassis been replaced? ☐ YES ☐ NO

11) Ambulance Manufacturer ____	Model ____	Year ____
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12) Current total mileage _____

13) Class for which Ambulance is to be certified: (check one class and one type)		
<input type="checkbox"/> Class I	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II
<input type="checkbox"/> Class II	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II
<input type="checkbox"/> Class III	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II
<input type="checkbox"/> Class IV	<input type="checkbox"/> Fixed Wing	<input type="checkbox"/> Rotary Wing
<input type="checkbox"/> Class V	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II

14A) Have waivers been issued for this? ☐ YES ☐ NO

If yes, please detail. Add extra sheets if necessary: _____

14B) This vehicle conforms to all applicable standards? ☐ YES ☐ NO

15) Has this vehicle been involved in a reportable accident since last inspection?

If yes, has the report(s) been filed with OEMS? If no, please attach report(s)

☐ YES ☐ NO
☐ YES ☐ NO

Weight Verification Form

To be completed with adding or replacing a new vehicle certification

NOTE: WEIGHT VERIFICATION IS REQUIRED ONLY FOR REPLACEMENT AND ADDITIONAL AMBULANCES. When requesting certification for multiple vehicles that have the same year of manufacture, design and construction specifications, a service need only take weight verification information on one sample vehicle from the group once during the chassis-manufacturing year and copy that information onto Part E, number 18 for the other identical vehicles in the group. For example, if a service is to purchase two or more identical ambulances manufactured in 2007, verify weight of one and put that information onto Part E, number 18 for other identical 2007 vehicles. Please do not complete this part for vehicles previously certified under your license.

Complete the following checklist to verify the weight of stocked ambulance:

1. Stock ambulance with required medical and vehicle equipment and supplies. ()
2. Stock ambulance with optional medical and vehicle equipment and supplies. ()
2. Count the number of seats that include seat belts and the cot. # of seats & Cot _____ ()
3. Stock ambulance as an in-service vehicle, with standard equipment required by the service for day-to-day operations. ()
4. Fill fuel tank(s) to full level. ()
5. Weigh stocked ambulance empty of personnel. ()
6. Record weight of ambulance Wt = _____ ()
7. Record gross vehicle weight (GVWR). GVW R= _____ ()
8. **Attach vehicle weight bill to this form.** ()

Note: If an ambulance is found to exceed its identified GVW rating, the service must take measures to reduce the weight in order to conform to the vehicle's posted GVW rating. Certification of an ambulance will be contingent on the licensee's ability to demonstrate compliance with the ambulance's GVWR.

Authorized Signature _____ Date _____

Print Name _____ Title _____

FEE INFORMATION:

The fee for certification is \$200.00 per vehicle.

Make check(s) payable to the **Commonwealth of Massachusetts.**

Return completed **Part E Form**, **Vehicle Weight Bill**, and **Certification Fee** to:

Office of Emergency Medical Services

**99 Chauncy Street, 11th Floor
Boston, MA 02111-1703**

OEMS use only	Fee Received	Amount	Certificate Number	Temp Certificate issued:
Wt _____ + # of Seats & Cot = _____ X 150lbs Wt Exceeds GVW Yes _____ No _____				
OEMS Review by _____				
Date _____				



Massachusetts Department of Public Health

Office of Emergency Medical Services
Affiliation Agreement Review



Please fill out the following form for review. Please review 105 CMR 170.300 with respect to affiliation agreements. These regulations have been modified and affiliation agreements should reflect those new requirements. The ambulance regulation program inspector will be reviewing these new requirements during the licensure process.

Name of Service _____

Inspector _____

Name of Hospital _____

Yes No

1. Is there an affiliation agreement in place with a hospital(s) licensed by the Department to provide medical control?		
2. Is the affiliation agreement(s) current?		
3. What is the expiration date on the agreement? ()		
4. Are the signatories in the agreement still the same as when the agreement was signed?		
5. Does the agreement address the requirement to abide by Statewide Treatment Protocols?		
6. Does the agreement provide for the hospital to designate an affiliate hospital medical director, who meets the requirements of 105 CMR 130.1504, to perform all the duties of 105 CMR 130.1503, including but not limited to authorization to practice of ALS-level EMTs?		
7. Who is this medical director designated by your affiliate hospital?		
8. Does the agreement provide for 24-hour on-line medical direction, by physicians who meet the requirements of 105 CMR 130.1504?		
9. Does the agreement provide for monthly review of trip records for ALS calls?		
10. Does the agreement provide for the hospital to operate a QA/QI program that includes regular review of trip records and other statistical data pertinent to the EMS service's operations, in accordance with the hospital's QA/QI processes?		
11. Are these trip record reviews and other QA/QI activities being conducted in accordance with what is described in the agreement?		
12. Does the agreement provide for regular consultation between medical and nursing staff and EMTs providing ALS?		
13. Does the agreement set out, at a minimum, how many M&M rounds the hospital makes available to EMTs providing ALS?		
Min Amount _____		

14. Do M&M rounds for ALS-level EMTs occur as called for in the agreement, and are ALS-level EMTs attending in accordance with the requirements in the agreement?		
15. Does the agreement provide for procedures for obtaining medications from the hospital pharmacy?		
16. Are there limits to what the hospital agrees to exchange/provide to the service?		
17. Does the agreement have provisions for quality assurance, quality improvement (i.e., min. skills/year)?		
18. Are trip records signed by a hospital physician or his/her designee?		
19. Does the agreement provide for the hospital to ensure EMS personnel have access to remediation, training and retraining as necessary under the oversight of the medical director?		
20. Does the agreement provide for skill maintenance and review for EMS personnel?		
21. Does skill maintenance and review occur as called for in the agreement?		
22. With which other hospital(s) does this service have affiliation agreements?		

OEMS Form 512-9 (9/10)

Comments:



Massachusetts Department of Public Health
Office of Emergency Medical Services
Part F: Contact Information



1) Service Number

2) Ambulance Service Name

Please complete the following information – Please note any changes as needed

Owner/Manager Name		Business Phone #	24hr. Access# non-911 or Cell	Email	Fax (if different from part “A”)
EMS Officer/Coordinator					
CQI Coordinator					
Medical Director					
Fleet Manager					
Compliance Officer					
Other					